GUIDELINES FOR INTERPRETING IN BSAS SETTINGS

BUREAU OF SUBSTANCE ABUSE SERVICES

DEPARTMENT OF PUBLIC HEALTH

Prepared for

Bureau of Substance Abuse Services
Interpreter Services Agencies/Individuals
Substance Abuse Service Providers

Prepared by

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EXECUTIVE SUMMARY

GUIDELINES FOR INTERPRETING IN BSAS SETTINGS

Office of Multicultural Health

In 2000 the White House issued Executive Order 13166 entitled "*Improving Access to Persons with Limited English Proficiency.*" This order required federal agencies to ensure that their funded programs, inclusive of medical, home and social services, serve individuals with LEP. Because of their enabling legislation requirements and because all BSAS programs receive federal funds, they are subject to this order.

BSAS providers have been working with the Office of Multicultural Health (OMH) in providing language interpretation services to their clients. However, in evaluating this service, OMH has found that both interpreters and clinicians confront challenges in working in BSAS settings. In order to address these challenges, BSAS and the OMH convened a working group on Interpreting with the charge to develop a uniform set of guidelines/recommendations for interpreting in substance abuse practice settings. The Committee was composed of members from community based programs, BSAS and OMH staff, and an interpreter, and met over a 6 month period.

The guidelines provide:

- An overview of and background information on interpretation
- General policy considerations for BSAS programs using interpreters
- Basic information about obtaining interpreter services authorization through OMH.
- Information about how to work with an interpreter effectively
- Guidance on confidentiality in BSAS settings
- Examples of real-life situations written by the members of the working group

It is recommended that the guidelines be used when providing orientation to staff unfamiliar with the overall goal of the service and the clinical setting in which it is provided. In addition, this document presents partial information about the interpreter's profession and only reflects a general overview of such profession. This document is designed for use within the context of a Public Health setting, as is the case with BSAS.

CONTENTS

BACKGROUND

INTERPRETER SERVICES

The 2000 census identified that in Massachusetts almost 1 in 5 (18.2%) residents 5 years and older speaks a language other than English at home – slightly higher than the national average of 17%. Of those, 22% speak English "not well" or "not at all." Although the requirement to provide services and materials in the preferred language of the client is included in many federal laws, anecdotal information suggests that client and provider alike poorly understand the client's right to an interpreter at no cost. As the number of limited English proficient (LEP) individuals dramatically increased throughout the 1990s, the need to ensure their access to services became more apparent. According to the 2000 Executive Order 13166 entitled *"Improving Access to Persons with Limited English Proficiency"*, federally funded programs are required to ensure provision of services to individuals with LEP. All BSAS programs receive federal funds and are thereby subject to this order.

An important strategy providers utilize to meet the needs of their LEP clients is to hire bilingual staff. Staff members who share cultural backgrounds, as well as language, with clients may enhance cross-cultural communication. Self-identification as bilingual is not sufficient to ensure good communication. Ideally, bilingual staff's skills in both English and the foreign language need to be assessed. Furthermore, bilingual staff that consistently are called upon to interpret need to be well grounded in the skills, practice and ethics of interpreting.

The Bureau of Substance Abuse Services and the Office of Multicultural Health have worked together to ensure that clients have timely access to all substance abuse services. As a state agency, MDPH is required to contract with interpreters listed on the approved statewide vendor list. Some of the contractors have statewide capacity and some are regionally based; but all must adhere to state procurement standards. Although some interpreters are independent contractors, most work through interpreting agencies. In addition to the contractual requirements, OMH requires that interpreters assigned to BSAS providers be trained and proficient in the art of interpretation.

THE ROLE OF THE INTERPRETER

Interpreters are called upon in a variety of situations and settings. Over time it has become apparent that providers have developed assumptions about the role the interpreter plays. Understanding the interpreter's role is important to obtaining the desired outcome during the encounter and to effectively serve the client. The California Healthcare Interpreters Association identifies the following four interpreter roles as: message converter, message clarifier, cultural clarifier, and patient advocate[1]. The interpreter must integrate all four areas when performing her/his job.

> **Message Converter…**interpreters listen…observe body language, and convert the meaning of all messages from one language to another without unnecessary additions, deletions or changes in meaning…
>
> **Message Clarifier…**interpreters are alert for possible words or concepts that might lead to a misunderstanding…when there is evidence that any of the parties, including the interpreter, may be confused by a word or phrase, interpreters may need to interrupt the communication process…alert the parties that the interpreter is seeing signs of confusion…request or assist the speaker…to restate or describe the unfamiliar word…
>
> **Cultural Clarifier…**interpreters go beyond word clarification to include a range of actions that typically relate to an interpreter's ultimate purpose of facilitating communication between parties not sharing a common culture…
>
> **Communication Advocate…**an individual patient's health and well-being is at the heart of the patient advocate role…patient advocacy can be as simple as suggesting that the patient needs an interpreter scheduled for follow-up appointments or giving the patient information needed to lodge a complaint…

It is important to keep in mind that the "appropriate role" for the interpreter is the *least invasive* role that assures effective communication between the provider and the client.[2]

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1 California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention, accessed on 10/04/05 at http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf

2 Cross Cultural Health Care Program, Diversity Rx, accessed on 10/04/05 at http://www.diversityrx.org/HTML/MOIPR3.htm

BSAS AGENCY CONSIDERATIONS

Staff members within BSAS programs have varying levels of experience in using this service. The following guidelines are provided to help provider agencies that contract with BSAS to identify policies, procedures and activities to ensure access to LEP. These guidelines are divided into different sections and provide recommendations for the development of policies and procedures and effectively working with interpreters.

Provider Agencies Should:

- Develop policies and procedures, regardless of funding stream, that ensure LEP clients access to substance abuse service.

- Create procedures for tracking interpreter services.

- Include LEP clients in your quality assurance efforts.

- Help staff identify if and how practice changes with an interpreter present and resolve concerns/conflicts about practice adaptation. Understand that interpreter-assisted sessions often mean longer sessions.

- Consider having interpreters sign a confidentiality agreement.

- During an intake interview, discuss the core treatment elements with the client and talk about ways to communicate when an interpreter is not available.

- In a residential program, clarify the use of interpreters for core program elements (assessments, treatment sessions, etc.)

- Encourage the clinician to have a brief pre-session with the interpreter. This will be an opportunity, among other things, to inform the interpreter about the session's goals and objectives, and discuss specifics of substance abuse treatment and confidentiality issues.

- When employing a bilingual counselor, ensure their competency in both English and their foreign language.

- Avoid using bilingual staff who have not received formal interpreting training as interpreters.

- Ensure interpreter-client cultural/ethnic match as much as possible by informing OMH of the client's ethnic background.

It is Important that Provider Agencies:

- Do not ask the client to bring his or her own interpreter.
- Do not ask another client to interpret.
- Do not use children as interpreters.
- Avoid using family members as interpreters.

OHM Requirements:

1. Programs must obtain authorization from OMH for interpreters.
2. Clinical staff must sign the interpreter's timesheet upon session completion. All boxes on timesheets must be complete prior to the provider's signature. Do not sign blank or incomplete timesheets.
3. In case of a "no-show" client, have the interpreter help you place a phone call to the client to clarify the situation and confirm next appointment.
4. In case of a "no-show" interpreter, contact OMH immediately

EXPECTATION OF INTERPRETERS IN BSAS SETTINGS

Confidentiality

Federal substance abuse treatment regulations (42 C.F.R. Part 2) require that providers of substance abuse services maintain confidentiality of consumers and families. The interpreter must treat all information learned during the interpretation as confidential. The following are ways to ensure that confidentiality is maintained.

- Advise counselor and client that the interpreter will respect the confidentiality of the client/provider interaction outside of the program/treatment setting.
- Interpret everything communicated within the session to all parties.
- Refrain from disclosing to providers any information about the client gained in a community context without client's full approval. (This may happen in linguistic communities that are demographically small.)
- Never discuss or repeat any information disclosed at the time of interpreting.

Professional Boundaries:

The interpreter will abide by the following ethical considerations and may not:

- Spend time alone with clients.
- Solicit business from providers but contact DPH/OMH directly.
- Provide services beyond the scope of interpreting for BSAS program such as transportation.
- Secure information from clients without providers present.
- Provide personal information to clients.
- Make service arrangements outside of the agreement described by OMH Interpreter Service Authorization.
- Bring personal experiences about issues presented during the session.

OMH Requires Interpreters to:

- Submit appropriate and <u>complete</u> documentation; timesheets must contain <u>all</u> information required in the boxes and the provider's signature.

- Arrive on time.

- Respect client's privacy; keep client information confidential.

- Acknowledge language limitations; ask for clarifications.

- Not give your personal opinion regarding treatment.

- Not advise the client.

APPENDIX

Below interpreters/clinicians will find a series of situations that may serve as reference to solving some of the challenges occasionally faced by clinicians and interpreters. Also, you will find a list of resources for further readings and information.

EXAMPLES

BSAS clinicians repeatedly identified two challenges in providing services to clients from diverse cultural and linguistic backgrounds: cross-cultural miscommunication in substance abuse treatment and understanding the multiple and varied cultural customs and attitudes regarding alcohol.

PRE-SESSION

Situation: A Korean-speaking client was admitted to an outpatient DAE program. In order to provide linguistic access a Korean interpreter was assigned to interpret for the full 16-week program. However, the interpreter had no prior experience with BSAS programs. The DAE counselor, on his part, had no previous experience with Korean-speaking clients.

Strategies:

- Being unfamiliar with program materials and key concepts, the interpreter requested program literature to read to familiarize herself with the specific language and issues of substance abuse.
- Prior to the initial intake, the counselor spoke with the interpreter to become familiar with how alcohol consumption is viewed in Korean culture. The interpreter educated the counselor on the different drinking customs, types of alcoholic beverages, and alcoholic content of commonly used drinks in Korea.
- During the pre-session, the counselor and the interpreter agreed to a post-session time to confer about client's understanding of the treatment.

ASSUMPTIONS AND ATTITUDES

Situation: Based on the assumption that speaking the same language is both necessary and sufficient in providing effective cross cultural services, two clients, one Cape Verdean and the other Brazilian were grouped together in an outpatient DUI program. Both Cape Verde and Brazil are known for speaking Portuguese, although each country has its particular version of Portuguese. The interpreter contracted for the duration of this group was from Portugal and also spoke Portuguese. Although all three could communicate in Portuguese, their experiences and backgrounds were very different. These differences were not apparent to the counselor until the sessions began.

Strategies:

- Once aware that the interpreter could not provide a cultural context, the DUI counselor encouraged a discussion of drinking and the expectations and consequences of drunk driving in each clients' culture.
- The counselor addressed the consequences of drunk driving in Massachusetts and compared these to each client's expectations.
- The counselor informed OMH of his experience with Cape Verdean and Brazilian clients. Information about the client's country of origin was incorporated into the initial OMH assessment to help match interpreter and client.

PROFESSIONAL BOUNDARIES

Situation: During an initial interview, a client makes offensive and embarrassing comments.

Strategies:

- This is a common interpreter concern. Professional, experienced interpreters have three ways of approaching such a situation: translate these remarks word for word, use the third person to create distance or indicate that the client is making an offensive comment. At this particular session the interpreter decided to indicate that the client was making an offensive comment.
- Knowing that all information is important in clinical settings, the counselor asked the interpreter to continue interpreting word for word and assured the interpreter that this was appropriate for treatment.
- The counselor determined that in the future, she would have direct contact with the interpreter prior to the session to ensure that interpreters understand the importance of the client's voice.
- The interpreter also realized the importance of clarifying such situations and determined that his future practice included a pre-session time for clarification of such issues.

COMMUNITY AND CULTURAL TIES

Situation: After an intake session had been completed, the client spoke to his probation officer (through an unofficial interpreter) and told him that he had been very uncomfortable during the session because he knew the interpreter. Furthermore, he indicated that there was "bad blood" between them. He expressed frustration at not being able to communicate this discomfort to the clinician. Since the interpreter never informed the clinician of his prior connection with the client outside of interpreting, the counselor had to resolve this situation through OMH.

Strategies:

- The counselor called the OMH Coordinator of Interpreter Services and issued a formal complaint. OMH followed up with the agency, requested an investigation and indicated that this interpreter not be assigned to a DPH assignment again.

- The program assisted the client with re-engagement. OMH identified another interpreter to work with the counselor.
- At the first session, the client brought his own interpreter and only after seeing the new interpreter and discussing what had happened would he agree to further treatment.

Note: When a client is reluctant or hesitant to cooperate, the counselor should inquire whether the interpreter knows the client or has interpreted in other situations. The ethics of interpretation are clear. When an interpreter knows the client from a community perspective, the interpreter is to explain the circumstances to the clinician and decline interpreting. Although declining at the time of service delivery is inconvenient, it is in the client's best interest and may facilitate engagement in treatment.

GLOSSARY OF TERMS

Interpretation is the process by which an interpreter translates one language orally and live into another language. Interpretation refers to the process of conveying a message using the **spoken** word and not necessarily word for word translation.

Translation is the process by which a written message is translated into another language in a **written** format.

FURTHER READING

OFFICE OF CIVIL RIGHTS, LAWS AND REGULATIONS REQUIRING LANGUAGE ASSISTANCE
http://www.hhs.gov/ocr/lep/appb.html

ACCESS FOR PEOPLE WHO ARE LIMITED ENGLISH PROFICIENT
http://www.lep.gov/

MASSACHUSETTS MEDICAL INTERPRETERS ASSOCIATION (MMIA) CODE OF ETHICS
http://www.mmia.org/standards/CodeofEthics.asp

CALIFORNIA STANDARDS FOR HEALTHCARE INTERPRETERS (CHIA)
http://www.calendow.org/reference/publications/pdf/cultural/ca_standards_healthcare_interpreters.pdf

NATIONAL CODE OF ETHICS FOR INTERPRETERS IN HEALTH CARE (NCIHC)
http://ncihc.org/NCIHC_PDF/NationalCodeofEthicsforInterpretersinHealthCare.pdf

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Written by Brunilda Torres, LICSW, Director, OMH; Jordan J. Coriza, Coordinator of Interpreter and Translation Services, OMH; Jenya Krein, Former Coordinator of Interpreter and Translation Services, OMH.